

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

### **I. DISPUTE**

1. a. Whether there should be additional reimbursement for date of service 07/02/01.
- b. The request was received on 03/25/02.

### **II. EXHIBITS**

1. Requestor, Exhibit I:
  - a. TWCC 60 and Request for Medical Dispute Resolution
  - b. HCFAs-1500
  - c. TWCC 62 forms
  - d. EOBs from other insurance carriers
  - e. Medical documentation
  - f. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
2. Respondent, Exhibit II: No Response
3. Per Rule 133.307 (g) (4), the Division forwarded a copy of the requestor's additional documentation to the carrier on 06/28/02. The respondent did not respond to the additional documentation.
4. Notice of Additional Information submitted by Requestor is reflected as Exhibit III of the Commission's case file.

### **III. PARTIES' POSITIONS**

1. Requestor: Letter dated 06/15/02  
"Total dollar amount in dispute is **\$80.30**. The disputed issue is that the Carrier has paid \$50.00 for the back therapy kit stating "M" no MAR reduced to fair and reasonable.... The Carrier has not responded to our reconsideration request in a timely manner... The expected out come of this issue is that we feel the claims should be paid in full."
2. Respondent: No Response

### **IV. FINDINGS**

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 07/02/01.
2. The carrier denied the billed charges by denial codes, "M – NO MAR, REDUCED TO FAIR AND REASONABLE".

3. Per the provider's TWCC-60, the amount billed is \$147.25; the amount paid is \$66.95; the amount in dispute is \$80.30.
4. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MARS	REFERENCE	RATIONALE:
07/02/01	E1399 (back therapy kit)	\$100.00	\$50.00	M	DOP	Rule 133.307 (g) (3) D); HCPCS descriptor	A copy of the provider's additional information was received by the carrier on 06/28/02, but the carrier failed to respond. The other carrier EOBs submitted by the provider proved to be sufficient to meet the criteria of Rule 133.307 (g) (3) (D). Reimbursement in the amount of <b>\$80.30</b> is recommended.
	E0934 (cervical pillow)	\$47.25	\$16.95				
<b>Totals</b>		\$147.25	\$66.95				The Requestor <b>is</b> entitled to reimbursement in the amount of <b>\$80.30</b> .

## V. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit \$80.30 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 3<sup>rd</sup> day of February 2003.

Donna M. Myers  
Medical Dispute Resolution Officer  
Medical Review Division

DMM/dmm